

00-07599

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Department of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8614375		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Naomi Grace Adkins</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>05 21 86</i>		2b. HOUR <i>0930</i> M			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>02 15 03</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i> MD			
10. CITY OR TOWN OF DEATH <i>Taneytown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2 Fairview Avenue</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Taneytown</i>		13d. STREET ADDRESS / ZIP CODE <i>2 Fairview Avenue 21787</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Sines</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Eva Haupt</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>219-36-1854D</i>		17. INFORMANT <i>Family</i>		ADDRESS <i>Same</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrhythmia</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>AA SCVD</i>								<i>5 yrs</i>	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>Diverticulosis Diabetes</i>									
19a. DATE OF OPERATION <i>5-7-86</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>77</i> , to <i>May</i> , 19 <i>86</i> , that (I) (we) lost saw the deceased alive on <i>May 1</i> , 19 <i>86</i> , and that in <i>(b)</i> (our) opinion death occurred on the date and hour and from the causes stated above <i>(b)</i> (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Alva S. Baker MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>5-21-86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alva S. Baker</i>				22e. ADDRESS <i>1 King's Drive Taneytown MD 21787</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>05/24/86</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Reformed Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Middletown, Frederick, MD</i>			
24. FUNERAL DIRECTOR NAME <i>Skiles Funeral Home</i>				136 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR <i>MAY 23 1986</i>		25b. REGISTRAR'S SIGNATURE <i>John G. Baker</i>	

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London 02/11/52

21st Street, New York, N.Y. 10003

00-08278

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 3 7 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Robert N. Bankert</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>5 21 86</u>		2b. HOUR <u>0610</u>
3. SEX <u>male</u>	4. RACE <u>white</u>	5. DATE OF BIRTH MONTH DAY YEAR <u>12-01-01</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>	7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Carroll County</u> MD.	
10. CITY OR TOWN OF DEATH <u>Westminster</u>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Carroll County General Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <u>Md.</u>	13b. COUNTY <u>Carroll</u>	13c. CITY OR TOWN <u>Hampstead</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <u>416 Houcksville Rd. Hampstead Md. 21074</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>George H. Bankert</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Martha V. Dutterer</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES; NO OR UNKNOWN) <u>unknown</u>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <u>unknown</u>	17. INFORMANT ADDRESS <u>Mrs. Robert N. Bankert, Hampstead, Md.</u>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVAConditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) CEREBRAL INFARCTION
(c)APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHPART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Renal Failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5-20-86</u> to <u>5-21-86</u> , that (I) (we) last saw the deceased alive on <u>5-20-86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Manuel J. Sevilla</u>	DEGREE <u>MD</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>5-21-86</u>
22d. PHYSICIAN'S NAME (PRINT NAME) <u>Manuel J. Sevilla</u>		22e. ADDRESS <u>601 Murray Rd. WESTMINSTER</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>5-23-86</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hampstead Cemetery</u>	23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hampstead Carroll Md.</u>
24. FUNERAL DIRECTOR NAME ADDRESS <u>Eline Funeral Home, Hampstead, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JUN 3 1986</u>	
		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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00-07909

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Thereafter, the funeral director should remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "yes," the medical examiner must be notified.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

36

14377

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) James B. Barnes		5-25-86		8:00 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 11 27 37	6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.		
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GEN. HOSP.	12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) BUILDER, Apartment	12b. KIND OF BUSINESS OR INDUSTRY Owner		
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2651 Ridge Rd. 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Vernon H. Barnes Jr.	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louise Logue		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 216-36-5121		17. INFORMANT NAME ADDRESS Rebecca D. Barnes same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA OF THE KIDNEY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/25 , 19 86 , to 5/25 , 19 86 , that (1) (we) last saw the deceased alive on 5/25 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard G. Canham MD		DEGREE MD		22c. DATE SIGNED 5/25/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD G. CANHAM, MD		22e. ADDRESS 215 WASHINGTON RD'S MEDICAL CTR WESTMINSTER 21157			
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	5-28-86	Stone Chapel	Westminster Carroll Md.		
24. FUNERAL DIRECTOR NAME Thomas D. Fleck		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE May 28 1986	
Westminster Md.					

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00-07749

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna E Bell		2a. DATE OF DEATH MONTH DAY YEAR 5/27/86	
3. SEX Female		2b. HOUR 0740 M	
4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3 27 20	
6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster		7b. CITIZEN OF WHAT COUNTRY? U.S.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crossing Guard Balt.		12b. KIND OF BUSINESS OR INDUSTRY City Police Dept.	
13a. STATE Maryland		13b. COUNTY Carroll	
13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 4703 London Bridge Road 21784			
14. FATHER'S NAME FIRST MIDDLE LAST Franklin Joseph Miller		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Diesel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-3532	
17. INFORMANT Millard M. Bell, Jr.		ADDRESS 4703 London Bridge Rd Sykesville, MD 21784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Bowel Obstruction, Necrosis & Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Adhesions from recurrent abdominal carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) carcinoma tumor APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs 12 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION 26 May 86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Small Bowel Obstruction	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 25 May 1986 to 27 May 1986, that (1) (we) last saw the deceased alive on 27 May 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Donald D. Coker MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 27 May 86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD		22e. ADDRESS 222 Washington Heights Medical Center	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 30, 1986	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, INC. ADDRESS 8728 Liberty Road Randallstown, MD 21133-4784		25a. DATE REC'D. BY REGISTRAR MAY 27 1986	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Pennell			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTICE TO THE PUBLIC

1911

1911



00-07285

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14379

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALICE BILLINGSLEY			2a. DATE OF DEATH MONTH DAY YEAR 5/11/86		2b. HOUR 1234 PM						
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR 20 1893		6. AGE (IN YEARS, LAST BIRTHDAY) 93 YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		8. UNDER 2 YEARS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1326 Deer Park Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1326 Deer Park Rd 21157			
14. FATHER'S NAME FIRST MIDDLE LAST John M. CORKRAN						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta DAVIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 218-52-2473		17. INFORMANT NAME ADDRESS IVAN REAVER 1648 Old Westminster Pike Westminster, MD					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CARDIAC ARRHYTHMIAAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **CONGESTIVE HEART FAILURE 3 WEEKS**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ARTERIO SCLEROTIC CARDIOVASC. DIS. - 10 YEARS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOV 25 19 85 to MAY 10 19 86 , that (I) (we) lost saw this deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (c) (d) (did not) view the body after death.							
22b. SIGNATURE Daniel I. Welliver				DEGREE MD		22c. DATES SIGNED 5/1/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER				22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD			

23a. BURIAL, CREMATION, REMOVAL (PRECISE) Burial		23b. DATE 5-13-86		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD	
24. FUNERAL DIRECTOR NAME ADDRESS Robert Kyle Pruitt, Jr. Westminster, Md.				25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson Rodes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filed with the funeral director. Page 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please return the burial-transit permit to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 50M 4/83

(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
<div> <div>FOR STATE REGISTRAR</div> <div> <div>6</div> <div>14380</div> <div>MAY 1 1986</div> </div> </div>										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY W. BRAKE					2a. DATE OF DEATH MONTH DAY YEAR 5 / 1 / 86		2b. HOUR 1:53 A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH NOV. 24, 1900 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WEST VA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD				
10. CITY OR TOWN OF DEATH MT. AIRY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4924 RIDGE ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINT. ENGINEER		12b. KIND OF BUSINESS OR PUBLIC SCHOOLS		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.					13b. COUNTY CARROLL		13c. CITY OR TOWN MT. AIRY		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE - BRAKE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE - CRITES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) * NO					16b. SOCIAL SECURITY NO. 579-09-6070		17. INFORMANT ADDRESS CAROL B. STRICKLER SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident; rt. hemiparesis DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Multiple strokes in past Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 6/1/85 , 19, to NOW , 19, that (I) (we) last saw the deceased alive on 5/1/86 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE J.H. Caricofe MD					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/1/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.H. CARICOFE MD					22e. ADDRESS 104N. Main; Union Bridge; MD 21791					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAY 3, 1986		23c. NAME OF CEMETERY OR CREMATORY FLOWER HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE REDLAND MONT. MD.				
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS H. BARBER LAYTONSVILLE, MD. 20879					25a. DATE REC'D. BY REGISTRAR MAY 2 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

0-13300

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2/1/82

DATE

TIME

LOCATION

REMARKS

X

WATER LEVEL 10.0

WIND 10 KTS

WAVE 10 FT

WATER TEMPERATURE 10.0

WIND

WAVE

WATER LEVEL 10.0 - 10.00

WAVE

Central station at bridge

Central station at bridge

Water level at bridge

X

WAVE

2/1/82

2/1/82

2/1/82

Water level at bridge

Water level at bridge

0-13300

0-13300

00-06089

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP _____

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1- FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR					2b. TIME	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Velma W. BRANDENBURG					May 5, 1986					7 pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.					
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 110 Shipley Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Mt. Airy					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 110 Shipley Ave. 21771				
14. FATHER'S NAME FIRST MIDDLE LAST Milton Watkins					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Phebus						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. 218-01-9019		17. INFORMANT ADDRESS M. Eugene Spurrier 1522 Glenn Keith Blvd. Baltimore, Md. 21204				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>thrombotic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myelitis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 mi	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> , 19 <u>78</u> , to <u>3-24</u> , 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>3-24</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Robert S. Hughes</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Hughes, M.D.				22e. ADDRESS 700 Montclair Ave., Frederick, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE May 9, 1986		23c. NAME OF CEMETERY OR CREMATORY Marvin Chapel		23d. LOCATION CITY OR TOWN COUNTY STATE Plane No. 4, Frederick, Md.			
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR MAY 9 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

MEDICAL CERTIFICATION

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1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The final part of the report is a conclusion and a list of references.

00-06357

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14382

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST ANNA B BROOKS		MONTH DAY YEAR MAY 10 1986		0845M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE	WHITE	MONTH DAY YEAR 6/18/47		88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	U.S.A.			CARROLL MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
WESTMINSTER	WESTMINSTER NUR & CONV. CTZ.		Housewife		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS / ZIP CODE	
MARYLAND		CARROLL	TANEYTOWN	15504 GREGG RD. Taneytown, Md.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Charles Brown		FIRST MIDDLE LAST Bertha Fischer		215-01-4103	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
		215-01-4103		2198 Tyrone Rd. - Westminster, Md. Mrs. Charles T. Unverzagt #21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) <u>CARDIOVASCULAR INSUFFICIENCY</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(b) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DIS.</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) <u>3 YEARS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>86</u> , to <u>5/10</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Daniel J. Welliver</u>		M.D.		<u>5/10/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
DANIEL J. WELLIVER M.D.		218 WASHINGTON HENRY HWY WESTMINSTER MD 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 13, 1986		Loudon Pk. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR			
Balto. Md.		MAY 13 1986			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR			
G. Trnman Schwab 5151 Balto. Nat'l. Pike #21229		MAY 13 1986			

NOTICE
COTTON



[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "COTTON" and "NOTICE" are visible.]

00-08652

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14383

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernice A. Burnette			2a. DATE OF DEATH MONTH DAY YEAR May 26, 1986			2b. HOUR 1158 M					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 3 00		6. AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) hairstresser		12b. KIND OF BUSINESS OR INDUSTRY hair			
13a. STATE Missouri			13b. COUNTY Macon		13c. CITY OR TOWN Macon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 1 63552		
14. FATHER'S NAME FIRST MIDDLE LAST Spencer M. McGrew			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora May Moore			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. n/a	
17. INFORMANT ADDRESS Frances McGrew 1049 Klee Mill Rd			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RENAL ACIDOSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from May 26 , 19 86 , to May 26 , 19 86 , that (I) (we) last saw the deceased alive on May 26 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John S. MARSNEY, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/26/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. MARSNEY, M.D.				22e. ADDRESS 8 Archer St. Westminster, Md. 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 5/30/86		23c. NAME OF CEMETERY OR CREMATORY Oakwood		23d. LOCATION CITY OR TOWN COUNTY STATE Macon Macon Md					
24. FUNERAL DIRECTOR NAME Westminster, Md PRITTS FUNERAL HOME 412 Washington Rd				25a. DATE REC'D. BY REGISTRAR JUN 02 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

00-06118

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14384

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST ANNA MARY CALTRIDER		2a. DATE OF DEATH MONTH DAY YEAR MAY 7 1986		2b. HOUR 2145	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR NOV 24 1893		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 158 E MAIN ST.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alvin Caltrider		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Caltrider		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-03-8433	
17. INFORMANT GLORIA JEAN DAYLOR		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ROBACOPNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from APRIL 86 to MAY 86 , 19 86 that (i) (we) lost saw the deceased alive on MAY 7 1986 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE Daniel I. Welliver MD		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/7/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/10/86		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville, Balto. Co. Md	
24. FUNERAL DIRECTOR NAME Burgee-Henss Funeral Home				25a. DATE REC'D. BY REGISTRAR MAY 9 1986			
ADDRESS 3631 Falls Rd 21211				25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-2-1945
1-2-1945
1-2-1945



SECTION 4-B
1-2-1945

1-2-1945

1-2-1945

00-07269

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 1 4 3 8 5

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACK T. CLICK		2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 5 10 86		2b. HOUR OF DAY 1:14
3. SEX m	4. RACE w	5. DATE OF BIRTH MONTH DAY YEAR 6 5 34	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH NEW Windsor		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt 75		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL
13a. STATE Md.		13b. COUNTY CARROLL	13c. CITY OR TOWN Union Bridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH Click		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Scheckrade		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-32-4245		17. INFORMANT MATHEW M. Click
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries, due to 8191 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. Single car accident (passenger) DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:00 5 10 86		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN PART I OR PART II) Single car struck side of road (passenger)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, ETC.) Funeral Road		21f. LOCATION (CITY OR TOWN, COUNTY, STATE) Route 75 south of New Windsor Carroll. Md.
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE Richard A. Loops		TITLE (SPECIFY) Deputy Medical Examiner		DATE SIGNED 10 May 86
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Loops		ADDRESS Carroll County General Hosp		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-13-86	23c. NAME OF CEMETERY OR CREMATORY MT VIEW		23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Emmitsburg Frederick Md
24. FUNERAL DIRECTOR NAME Pratt Funeral Home Westminster		25a. DATE REC'D. BY REGISTRAR MAY 19 1986		
ADDRESS Westminster		25b. REGISTRAR'S SIGNATURE John Davidson		

DIVISION OF VITAL RECORDS, 301 W. PRESIDENT ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 5. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSFER PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESIDENT STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M/7/77

00-06796

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 3 8 6

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE Elizebeth LAST Cook			2a. DATE OF DEATH MONTH DAY YEAR 05-14-86		2b. HOUR 1255M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 07-06-11		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Westminster	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sewing Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY
13a. COUNTY Carroll	13b. CITY OR TOWN Westminster Md.	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13d. STREET ADDRESS 1294 Washington Road 21157		
14. FATHER'S NAME FIRST MIDDLE LAST Carroll E. Hook		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Plattie Wimert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-10-2980		17. INFORMANT 2556 Albert Rill Rd. Hazel Eckard Westminster, Md. 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DIC</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>pneumonia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>N</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <u>5/12/86</u> to <u>5/14/86</u> that (1) (we) last saw the deceased alive on <u>5/12/86</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (we) did not view the body after death)					
22b. SIGNATURE <u>John Middleton</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>		22c. DATE SIGNED 5/14/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. John Middleton		22e. ADDRESS E. Main St. Westminster Md 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-17-86	23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.		
24. FUNERAL DIRECTOR NAME <u>John Fletcher</u>		25a. DATE REC'D. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>	



Dr. [illegible]

00-07339

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column 18a. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 3 8 7

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Velma Audie COOLEY		2a. DATE OF DEATH MONTH DAY YEAR May 19, 1986	
3. SEX Female		2b. HOUR 2:30 P.M.	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
5. DATE OF BIRTH MONTH DAY YEAR May 29, 1908		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.	
7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5614 Olde Oak Dr.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Carroll	
13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 716 Horpel Dr. 21771		14. FATHER'S NAME FIRST MIDDLE LAST William Henry Gilley	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Ray Tolman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 525-05-9419D		17. INFORMANT ADDRESS Gail Ann Crum, 5614 Olde Oak Dr. Mt. Airy, Md. 21771	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic lung cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u> <u>7 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>CHRONIC OBSTRUCTIVE LUNG DZ.</u>			
19a. DATE OF OPERATION <u>0</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11/1</u> , 19 <u>85</u> , to <u>5</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Kathryn P. Alberti, MD CPT, MC</u>		22c. DATE SIGNED 20 MAY 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHRYN P. ALBERTI, MD, CPT, MC		22e. ADDRESS USA Health Clinic, Ft Detrick, Frederick, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 23, 1986	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR MAY 22 1986	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

BP.

Handwritten notes in the top right corner, possibly a date or reference number.

Main body of handwritten text, appearing to be a list or series of entries. The text is faint and difficult to decipher.

Bottom section of the page containing additional handwritten text, possibly a conclusion or further notes. Includes some faint markings and lines.

0-08135

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

BP _____

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) HELEN JEANETTE CRAMM			2a. DATE OF DEATH MONTH 5 DAY 29 YEAR 86		2b. HOUR 5:45 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH 11 DAY 15 YEAR 18		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE MARYLAND	13b. COUNTY CARROLL	13c. CITY OR TOWN SYKESVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6350, Barnett Ave. 784	
14. FATHER'S NAME FIRST Wm MIDDLE Ernest LAST Hodgdon		15. MOTHER'S MAIDEN NAME FIRST Helen MIDDLE MARIE LAST Minnick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-01-4019		17. INFORMANT ADDRESS Edward C. Cramm Sykesville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-60 minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Severe COPD, alcoholic liver disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D. Seaberg		DEGREE MD		22c. DATE SIGNED 5/29/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Westminster, Md. 21157		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 6-2-86		23c. NAME OF CEMETERY OR CREMATORY Lake View Cemetery	
23d. LOCATION CITY OR TOWN Sykesville COUNTY Carroll STATE Md.		23e. DATE REC'D BY REGISTRAR JUN 2 1986			
24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sykesville, Md.		24b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION



00-06795

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mr. August T. DeLuca			2a. DATE OF DEATH MONTH DAY YEAR May 15 1986			2b. HOUR 9 30 AM									
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 2 1911		6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 9 30							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.									
10. CITY OR TOWN OF DEATH Eldersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2208 Longview Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer- C & P		12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.							
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Eldersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2208 Longview Drive 21784						
14. FATHER'S NAME FIRST MIDDLE LAST Adolph DeLuca				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Allen											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-03-6781			17. DECEASED'S NAME FIRST MIDDLE LAST Mr. Joseph DeLuca			ADDRESS 2208 Longview Drive Eldersburg Maryland 21784						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC MESOTHELIOMA DUE TO, OR AS A CONSEQUENCE OF (c) 3 YEARS Approximate interval between onset and death: 3 YEARS										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR APRIL 19 86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1702 Liberty Rd. Eldersburg, Md.									
22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 86 , to MAY 15, 19 86 , that (I) (last) saw the deceased alive on MAY 15 19 86 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (I) (did) (view the body after death).										22b. SIGNATURE Arthur J. Lomant MD		22c. DEGREE MD		22d. DATE SIGNED 5/16/86	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur J. Lomant MD						22f. ADDRESS 1702 Liberty Rd. Eldersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 05-17-86			23c. NAME OF CEMETERY OR CREMATORY Lake View Memorial Park			23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland						
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc.						25a. DATE REC'D. BY REGISTRAR MAY 16 1986			25b. REGISTRAR'S SIGNATURE [Signature]						
27. FUNERAL HOME ADDRESS 8728 Liberty Road Randallstown, Maryland 21133															

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove (detach) pages 1 and 2 should be filed within 72 hours after death.

WITH THE STATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, REMOVAL

BP



00-08042

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 3 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Robert Augustus Derreth			2a. DATE OF DEATH MONTH DAY YEAR 5 - 26 - 86		2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 - 26 - 25		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive	12b. KIND OF BUSINESS OR INDUSTRY Off. Machinery	
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Finksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William E. Derreth, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Emich			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII 213 20 9437		17. INFORMANT ADDRESS Margarete B. Derreth Finksburg, MD 21048	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>A.S.C.V.D</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immed:</u> <u>March 86</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> 19 <u>84</u> to <u>5/26</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on <u>7/6</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>William E. Derreth, Sr.</u>		DEGREE		22c. DATE SIGNED <u>5/27/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Ellin</u>		22e. ADDRESS <u>5310 Old Court Rd</u>		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> <u>Randall L. Brown, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-29-86	23c. NAME OF CEMETERY OR CREMATORY LAKE VIEW CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE CARROLL MD		
24. FUNERAL DIRECTOR NAME ADDRESS HAIGHT FUNERAL HOME SYKESVILLE, MD 21784			25a. DATE REC'D. BY REGISTRAR MAY 29 1986		
			25b. REGISTRAR'S SIGNATURE <u>J. Davidson</u>		

MEDICAL CERTIFICATION

10
35
60
35
60

7/8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers, pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

100

NO 100



Handwritten text, possibly a signature or name, appearing as "John P. ...".

Handwritten text at the bottom of the page, including "John P. ...".

00-08473

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 14391

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Doris			MIDDLE Louise			LAST Dietz			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 5			DAY 30			YEAR 1986			2b. HOUR		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 8 24 1943			6. AGE (IN YEARS) LAST BIRTHDAY 42 YRS.			IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 30 1986			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			MD.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick Co.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED WIDOWED			NEVER MARRIED DIVORCED			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custom Service Rep.			12b. KIND OF BUSINESS OR INDUSTRY Becker											
10. CITY OR TOWN OF DEATH Manchester			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, STREET ADDRESS) York St.			12c. STREET ADDRESS 21102			13a. STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Manchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3227 N. Main Street					
14. FATHER'S NAME FIRST MIDDLE LAST Donald Baxter Weddle			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Arnold			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-42-7650			17. INFORMANT Doris B. Ritz			ADDRESS 94 Carnival Drive Taneytown, Md. 21787											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suicide due to</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. <u>Gunshot wound to neck & head.</u> (b) <u>Gunshot wound to neck & head.</u> DUE TO, OR AS A CONSEQUENCE OF (c)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																										
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 5 30 1986						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1 OR PART 2) Gunshot wound														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>						21e. PLACE OF INJURY (STREET, RAILROAD, PARK, ETC.) None						21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3385 York St Manchester Carroll Md.														
22a. I certify that I took charge of the remains described above, held death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Richard A. Jones						TITLE (SPECIFY) Deputy						MEDICAL EXAMINER Carroll County General Hosp						DATE SIGNED 30 May 1986								
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones						ADDRESS Carroll County General Hosp																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 6-3-86						23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens						23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md.								
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son						25a. DATE REC'D. BY REGISTRAR JUN 4 1986						25b. REGISTRAR'S SIGNATURE Julia Davidson														

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

100-18178

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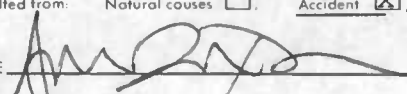
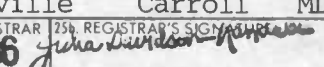
100-18178

00-08043

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14392

1. DECEASED NAME (TYPE OR PRINT) DOROTHY R. (W.) DOW			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 5-25-86			2b. HOUR M				
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 5 - 15- 27	6. AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 5-25-86			2d. HOUR 1:35P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10 CITY OR TOWN OF DEATH Floraville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #32, 1mi. S. of Church Street.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 115 Franklin Avenue 21784	
14 FATHER'S NAME FIRST MIDDLE LAST George Webbort			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Bushong							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-20-4971		17. INFORMANT ADDRESS Mr. James Dow Sykesville, MD 21784					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:15PM 5-25-86			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto in collision with multiple autos				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.			21f. ADDRESS Rt. #32, 1 mi. S. of Church St Floraville, Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 5-26-86	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn Street							
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 5-28-86		23c. NAME OF CEMETERY OR CREMATORY Wesley Freedom Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll MD		
24. FUNERAL DIRECTOR NAME ADDRESS HAIGHT FUNERAL HOME SYKESVILLE, MD 21784						25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE 		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MBP
DHMH - 17
(VR A15 ME (5))

RECEIVED



RECEIVED

00-07423

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 3 9 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Martin Luther Earhart		2a. DATE OF DEATH MONTH DAY YEAR 05-21-86		2b. HOUR 11:40 PM 23 09 M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR May-14-1928		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4841 Cherry Tree Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Food Town
13a. STATE Maryland		13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Franklin Earhart		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leeona Bowman Grubb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1950 1952 217-24-8222		17. INFORMATION ADDRESS Daisy M. Earhart 21784 4841 Cherry Tree Lane Sykesville Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) 2° widespread Metastasis of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF tumour kidney + ureter (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION 4.11.86		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. COLON		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-17 , 19 86 , to 5-21 , 19 86 , that (I) (we) last saw the deceased alive on 5-21 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If true, valid) (did not view the body after death).					
22b. SIGNATURE Regina Ruv		DEGREE MD		22c. DATE SIGNED 5-21-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYADURG GOVINDA RAO MD		22e. ADDRESS BALTIMORE COUNTY GENL HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05 24 86		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Maryland		25a. DATE REC'D. BY REGISTRAR MAY 23 1986			
24. FUNERAL DIRECTOR NAME ADDRESS Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, Maryland 21133		25b. REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Case No.

to show that

Case No.

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to show that

Case No.

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Case No.

to show that

Case No.

00-05849

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 1 1 4 3 9 4

1. DECEASED NAME (TYPE OR PRINT) CHARLES Joseph ERB			2a. DATE OF DEATH *MONTH DAY YEAR 5 2 86			2b. HOUR 11 A					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 23 05		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 0 0		8. IF UNDER 24 HRS. HOURS MIN. 0 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.					
10. CITY OR TOWN OF DEATH MANCHESTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Finisher			12b. KIND OF BUSINESS OR INDUSTRY Cement		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY CARROLL 13c. CITY OR TOWN WESTMINSTER						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 44 CARROLL ST. 21157			
14. FATHER'S NAME FIRST MIDDLE LAST John ERB				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDA HELwig							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1932-34		17. INFORMANT ADDRESS 44 CARROLL ST. WESTMINSTER MRS. ROLAND ZILE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chronic obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Chronic Bronchitis & Cerebral Vascular Insufficiency											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1980 19____ to May 2 19 86 , that (1) (we) last saw the deceased alive on 4/29 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Will Foard MD				DEGREE				22c. DATE SIGNED 5/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Will Foard MD				22e. ADDRESS 3223 Main ST Box E Manchester, Md 21102							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5/5/86		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley			23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD		
24. FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, Md				25a. DATE REC'D. BY REGISTRAR MAY 06 1986				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates of death from pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IBELL

IBELL



IBELL

IBELL

0-08039

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 5-28-86	23c. NAME OF CEMETERY OR CREMATORY MT. PAREN CEMETERY	23d. LOCATION CITY OR TOWN BALTIMORE COUNTY TOWNSHIP STATE MD
24. FUNERAL DIRECTOR NAME HAIGHT FUNERAL HOME SYKESVILLE, MD			25a. DATE REC'D BY REGISTRAR MAY 29 1986
			25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD (and stage)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <i>Hafeez A Syed</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 5/26/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAFAEEZ A SYED	22e. ADDRESS BALTIMORE COUNTY BEN HOSP	

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edgar Boyd Fowler			2a. DATE OF DEATH MONTH DAY YEAR 5 24 86		2b. HOUR M M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 28 15	6. AGE (IN YEARS LAST BIRTHDAY) YRS 70	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6101 Oak Hill Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Edgar Fowler		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lydia Boyd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-18-045	17. INFORMANT ADDRESS Hazel N. Fowler Sykesville, MD 21784			

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 6 1 4 3 9 5
FOR STATE REGISTRAR	REG. NO.	

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NOTICE



00-06459

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>EVA V. GRAF</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>5/3/86</i>		2b. HOUR <i>7:09 PM</i>
3. SEX <i>FEMALE</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>1 28 99</i>		6. AGE YEARS (LAST BIRTHDAY) <i>87</i>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>NEW YORK</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>CARROLL</i> MD.	
10. CITY OR TOWN OF DEATH <i>WESTMINSTER</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>CARROLL COUNTY GENERAL HOSP</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Virginia</i> 13b. COUNTY <i>Orange</i> 13c. CITY OR TOWN <i>Orange</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>Rt 1 Box 41 99999</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Hauptman</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna Cox</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>059-20-5070</i>		17. INFORMANT ADDRESS <i>Charles R. Graf 2570 Salem Bottom Rd. Westminister, Md.</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Ischemic perfusion - probable*
(c) *Shen ulcer*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>4/26</i> , 19 <i>86</i> , to <i>5/3</i> , 19 <i>86</i> , that (I) (we) last saw the deceased alive on <i>5/3</i> , 19 <i>86</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>John W. Middleton</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John W. Middleton</i>		22e. ADDRESS <i>182 East Main Street Westminster, Md.</i>	

23a. BURIAL (SPECIFY) <i>Burial</i>	23b. DATE <i>5-7-86</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Westminster</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westminster Carroll MD</i>
24. FUNERAL DIRECTOR NAME <i>Robert K. Pritts, Sr.</i>		412 Washington Rd. ADDRESS <i>Westminster, Md.</i>	25a. DATE REC'D. BY REGISTRAR <i>MAY 1 2 1986</i>
		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rodgers</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

00-07999

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14397
REG. NO.

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. DATE OF ESTI-MATED		22. MONTH		23. DAY		24. YEAR		25. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. FIRST		3. MIDDLE		4. LAST		5. DATE KNOWN OF DEATH		6. DATE OF ESTI-MATED		7. MONTH	
CHARLES F. GRIENSTREET								5-25-86		19		M	
8. SEX		9. RACE		10. DATE OF BIRTH		11. AGE (IN YEARS)		12. IF UNDER 1 YR.		13. IF UNDER 24 HRS.		14. DATE PRONOUNCED DEAD	
Male		White		April 10, 1916		70 YRS.		MONTHS		DAYS		HOURS	
15. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		16. CITIZEN OF WHAT COUNTRY?		17. MARRIED		18. NEVER MARRIED		19. WIDOWED		20. DIVORCED		21. BALTIMORE CITY OR COUNTY OF DEATH	
Maine		U.S.A.		X								Carroll County MD.	
22. CITY OR TOWN OF DEATH		23. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		24. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		25. KIND OF BUSINESS OR INDUSTRY		26. CITY OR TOWN OF DEATH		27. STATE		28. COUNTY	
Floraville		Rt. #32, 1mi. S. of Church Street		Carpenter		Construction		29. CITY OR TOWN OF DEATH		30. STATE		31. COUNTY	
32. FATHER'S NAME		33. MOTHER'S MAIDEN NAME		34. INSIDE CITY LIMITS?		35. STREET ADDRESS		36. CITY OR TOWN		37. STATE		38. COUNTY	
Edward Wm. Greenstreet		Helen Edlund		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9220 Old Montgomery Road		Columbia		21045			
39. WAS DECEASED EVER IN U.S. ARMED FORCES?		40. SOCIAL SECURITY NO.		41. INFORMANT		42. ADDRESS		43. CITY OR TOWN		44. STATE		45. COUNTY	
No		579-05-7192		Margaret Greenstreet		Same as # 13		Columbia		21045			
46. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		47. PART I DEATH WAS CAUSED BY:		48. IMMEDIATE CAUSE (a)		49. DUE TO, OR AS A CONSEQUENCE OF		50. (b)		51. DUE TO, OR AS A CONSEQUENCE OF		52. (c)	
8120		Chest injuries											
53. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		54. DATE OF OPERATION		55. CONDITION FOR WHICH OPERATION WAS PERFORMED?		56. AUTOPSY?		57. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		58. DATE OF OPERATION		59. TIME OF INJURY	
		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. DATE OF OPERATION		22. TIME OF INJURY	
23. EXTERNAL CAUSE WAS		24. TIME OF INJURY		25. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		26. LOCATION		27. CITY OR TOWN		28. COUNTY		29. STATE	
UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		12:15P 5-25-86		driver of auto head-on collision		Rt. #32, 1mi. S. of Floraville, Md.		Church Street		Floraville, Md.			
30. INJURY OCCURRED		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		32. CITY OR TOWN		33. COUNTY		34. STATE		35. DATE OF OPERATION		36. TIME OF INJURY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		howy.		Rt. #32, 1mi. S. of Floraville, Md.		Church Street		Floraville, Md.		5-25-86		12:15P	
37. I certify that I took charge of the remains described above, held on		38. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		39. death resulted from:		40. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		41. TITLE (SPECIFY)		42. DATE SIGNED		43. MEDICAL EXAMINER	
44. ACTUAL SIGNATURE		45. M.D. Assistant		46. DATE SIGNED		47. MEDICAL EXAMINER		48. DATE SIGNED		49. MEDICAL EXAMINER		50. DATE SIGNED	
49. EXAMINER'S NAME (TYPE OR PRINT)		50. ADDRESS		51. DATE SIGNED		52. MEDICAL EXAMINER		53. DATE SIGNED		54. MEDICAL EXAMINER		55. DATE SIGNED	
Margarita A. Korell, M.D.		111 Penn Street		5-25-86		Margarita A. Korell, M.D.		5-25-86		Margarita A. Korell, M.D.		5-25-86	
60. BURIAL, CREMATION, REMOVAL (SPECIFY)		61. DATE		62. NAME OF CEMETERY OR CREMATORY		63. LOCATION		64. COUNTY		65. STATE		66. DATE REC'D. BY REGISTRAR	
Burial		5/29/86		Crestlawn Cemetery		Marriottsville		COUNTY		Maryland		MAY 29 1986	
67. FUNERAL DIRECTOR		68. NAME OF FUNERAL HOME		69. ADDRESS		70. CITY OR TOWN		71. COUNTY		72. STATE		73. DATE REC'D. BY REGISTRAR	
Leroy M. & Russell C. Witzke Funeral Homes P.A.		5555 Twin Knolls Road, Columbia, MD. 21045		5555 Twin Knolls Road, Columbia, MD. 21045		5555 Twin Knolls Road, Columbia, MD. 21045		5555 Twin Knolls Road, Columbia, MD. 21045		5555 Twin Knolls Road, Columbia, MD. 21045		MAY 29 1986	

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

D7/84
25M

BP
DHMH - 17
(VR A15 ME (1))

2025 COLON JAMES

DAVID M. JAMES



0-07249

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please to have carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other final disposition. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8614398											
1- FOR STATE REGISTRAR					2a DATE OF DEATH MONTH DAY YEAR 5-14-86							2b. HOUR 3 ²⁵ M									
1. DECEASED NAME FIRST MIDDLE LAST Vernon L Houck					3. SEX MALE					4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 2-27-1914		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7b. CITIZEN OF WHAT COUNTRY? USA.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.					10. CITY OR TOWN OF DEATH WESTMINSTER					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1418 PINCH VALLEY RD.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER					12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. STATE MD.					13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1418 PINCH VALLEY RD., 21157										
14 FATHER'S NAME FIRST MIDDLE LAST NEVITT B. HOUCK					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOLA A. LEISTER					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO					16b. SOCIAL SECURITY NO. 216-03-9191		17 INFORMANT ADDRESS MARY S. HOUCK 13e 21157				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Pancreas</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN FINDING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>86</u> , to <u>5/14</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>April</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>John E. Steers</u> MD					DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <u>5/14/86</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John E. Steers MD					22e. ADDRESS 222 Washington Hts, Westminster, Md																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 5-16-86		23c. NAME OF CEMETERY OR CREMATORY KRIDERS			23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER CARROLL MD.											
24 FUNERAL DIRECTOR Robert E. Priddy Jr. Westminster, Md					25a. DATE REC'D. BY REGISTRAR MAY 19 1986					25b. REGISTRAR'S SIGNATURE John Davidson-Pandora											

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MR. CARROLL WESTMINSTER

BEVITT & HOUSE

NO. 218-O-SUMMARY B. HOUSE 120 EIGHT



WESTMINSTER CARROLL & MR.

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00-08279

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

14399

1. DECEASED NAME (TYPE OR PRINT)			FIRST Michael			MIDDLE B.			LAST Huemmer			2a. DATE KNOWN OF DEATH ESTIMATED XX MONTH DAY YEAR 5-24 19 86			7b. HOUR M 7:18 p. M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 1 1961		6. AGE (IN YEARS) LAST BIRTHDAY 24 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-24 19 86			7d. HOUR p. M				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.							
10. CITY OR TOWN OF DEATH Westminster				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician				12b. KIND OF BUSINESS OR INDUSTRY Electrical					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
13a. STATE Maryland				13b. COUNTY Carroll				13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 2633 Coon Club Road 21157			
14. FATHER'S NAME FIRST MIDDLE LAST James J. Huemmer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Meinschein													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-90-2703						17. INFORMANT ADDRESS Mrs. Ellen Huemmer, Westminster, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE <i>Robert E. Smith, M.D.</i>						TITLE (SPECIFY) M.D. Assistant						DATE SIGNED 5-25-86							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial						23b. DATE 5-28-86						23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cem.							
23d. LOCATION CITY OR TOWN Westminster						COUNTY Carroll						STATE Md.							
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.												25a. DATE REC'D. BY REGISTRAR JUN 3 1986		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MD. 21201

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(VR A15 ME (5))

01-00515

DAVID MINTHARD

REAR MOTOR



00-06408

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6

1 4 4 0 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SAUL John HUGHES			2a. DATE OF DEATH MONTH 5 DAY 5 YEAR 86 9.29 A.M.		
3. SEX MALE	4. RACE white	5. DATE OF BIRTH MONTH 3 DAY 12 YEAR 37	6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ind. Engineer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST George W. Hughes		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Honeycutt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. 1957-1962 215-34-5618		17. INFORMANT Mrs. Beverly Hughes, Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF <u>CAD</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>S/p M I . s/p Angioplasty</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>D. S. Kalaria</u>		DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/5/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DINESH . S. KALARIA		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-8-86	23c. NAME OF CEMETERY OR CREMATORY Leister's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR NAME Eline Funeral Home,		ADDRESS HAMPstead, Md.		25a. DATE REC'D. BY REGISTRAR MAY 14 1986	
				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



00-05559

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

86 14401

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND B. HUNTER			2a. DATE OF DEATH MONTH DAY YEAR 5 4 86			2b. HOUR 4 ¹⁶ M	
3 SEX male		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR 01 14 03		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminister		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Furniture	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Francis L. Hunter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Gauntt		13e. STREET ADDRESS 3337 Victor St. 21102			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 578-01-8484		17. INFORMANT Nettie Hunter		ADDRESS 3337 Victor St. Manchester, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATHEROSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. certify that (I) (this hospital) attended the deceased from <u>5-4-</u> 19 <u>86</u> , to <u>5-4-</u> 19 <u>86</u> , that (I) (we) lost saw the deceased alive on _____ 19 _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) [did] [did not] view the body after death.							
22b. SIGNATURE (signature) MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5-4-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. RAJPARA MD		22e. ADDRESS 224 WASHINGTON TR. WESTMINSTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 7, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Johns Luth. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE L. Hestown Penna.	
24. FUNERAL DIRECTOR NAME H. J. Ehlhardt		ADDRESS Manchester, Md.		25a. DATE REC'D. BY REGISTRAR MAY 5 1986		25b. REGISTRAR'S SIGNATURE (signature)	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

00-08634

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614402

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NILMA HOWELL KARCHER			2a. DATE OF DEATH MONTH 5 DAY 25 YEAR 86			2b. HOUR 3:50 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 11 DAY 26 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 85		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 74 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NURSE		12b. KIND OF BUSINESS OR INDUSTRY MEDICAL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 123A Washington Rd. 21157					
14. FATHER'S NAME FIRST ROBERT MIDDLE LEE LAST HOWELL				15. MOTHER'S MAIDEN NAME FIRST ELVA MIDDLE SPENCER LAST 							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT ADDRESS 21157 30 COURT ST MRS. MARY LOU DEWEY WESTMINSTER, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NA											
19a. DATE OF OPERATION NA		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. NA 19 86		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA		21f. LOCATION STREET NA		CITY OR TOWN NA		COUNTY NA		STATE NA	
22a. I certify that (a) (this hospital) attended the deceased from 5/22/86 , 19 86 , to 5/25 , 19 86 , that (b) (we) last saw the deceased alive on 5/25 , 19 86 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (and) (did not) view the body after death.											
22b. SIGNATURE John W. McAdams				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John W. McAdams				22e. ADDRESS 182 E. Main Street Westminster Md 21157							
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE MAY 26 1986		23c. NAME OF CEMETERY OR CREMATORY CARROLL CEMETERY		23d. LOCATION CITY OR TOWN HAMPSTEAD COUNTY Carroll STATE MD		24. FUNERAL DIRECTOR Robert A. Myers 911 WILKINS ST. AD. 21157			
DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE John W. McAdams							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate from the file and return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

S. A.

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00-07273

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate from the file. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 0 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Herbert Francis Kessler			2a. DATE OF DEATH MONTH DAY YEAR May 16, 1986		2b. HOUR 10:45_M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 2, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS 3 14
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.		
10. CITY OR TOWN OF DEATH Woodbine	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7737 Woodbine Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bartender-Ret.		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Woodbine	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Windsor L. Kessler			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST E. Sherman Buckingham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-07-4495		17. INFORMANT ADDRESS Marjorie A. Kessler, Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Anemia (aplastic) DUE TO, OR AS A CONSEQUENCE OF (c) Terminal Ca of prostate					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH One week One year 2 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) ---	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 28, 1968 to May 16, 1986 , that (I) (we) lost saw the deceased alive on Oct 17, 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Sani Okutman MD		DEGREE MD		22c. DATE SIGNED 5.16.86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sani Okutman		22e. ADDRESS Sykesville Md 21784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-19-1986		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodbine, Carroll, Md.		23e. DATE REC'D BY REGISTRAR MAY 20 1986			
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr.,		ADDRESS Sykesville, Md..		25. REGISTRAR'S SIGNATURE Julia Burrier	

BP



0-08526

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 4 0 4 REG. NO.																			
1- STATE REGISTRAR																													
1 DECEASED NAME (TYPE OR PRINT) Paul					FIRST B. MIDDLE KROH LAST					2a DATE OF DEATH MONTH 5 DAY 17 YEAR 86					2b HOUR 12.3														
3 SEX male					4 RACE white					5 DATE OF BIRTH MONTH 03 DAY 01 YEAR 08					6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS					IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. 									
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.					7b CITIZEN OF WHAT COUNTRY? USA					8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.														
10 CITY OR TOWN OF DEATH Westminster					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE					12b KIND OF BUSINESS OR INDUSTRY SCHOOLS									
13a STATE MD. 13b COUNTY Carroll 13c CITY OR TOWN Westminster										13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET ADDRESS / ZIP CODE 810 Littlestown Pike 21157														
14 FATHER'S NAME FIRST Clinton MIDDLE W. LAST Kroh										15 MOTHER'S MAIDEN NAME FIRST Estella MIDDLE LAST Bachman																			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					16b SOCIAL SECURITY NO. na					17 INFORMANT ADDRESS Reisterstown, Md. 21136 Paula Schwartzman, 77 Shetland Circle																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: HYPERTENSION.															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
19a DATE OF OPERATION					19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK					21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)					21f LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a I certify that (I) (this hospital) attended the deceased from 5-14- 19 86 to 5-17- 19 86 , that (I) (we) last saw the deceased alive on 5-17- 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22b SIGNATURE Chitrachedu Nagananna DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c DATE SIGNED 5/17/86				
22d PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NAGANNA										22e ADDRESS 700A poole Rd. Westminster MD 21157																			
23a BURIAL, CREMATION, REMOVAL (TYPE) Burial					23b DATE 5/20/86					23c NAME OF CEMETERY OR CREMATORY Krider's					23d LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD														
24 FUNERAL DIRECTOR NAME Robert K. Pritts, Sr., Westminster, MD										25 DATE OF REGISTRATION MAY 28 1986										26 REGISTRAR'S SIGNATURE Jane Davidson									

BP

0-08-20

2000

UNITED STATES
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

RECEIVED
JAN 10 1900
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

00-07465

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614405
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN		MIDDLE J.		LAST LANGRILL		2a. DATE OF DEATH MONTH DAY YEAR May 19, 1986		2b. HOUR 7:15 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD							
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2674 Walston Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wire Chief- Amtrak		12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2674 Walston Rd. 21771					
14. FATHER'S NAME FIRST MIDDLE LAST Henry Langrill		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna McCormack											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMANT Mrs. Mary Grace Langrill		ADDRESS Same as # 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF (b) ADENOCARCINOMA OF LUNG DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (1) (this hospital) attended the deceased from MAY 8 , 19 84 , to MAY , 19 86 , that (1) (we) lost saw the deceased alive on DEC , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (1) (we) (did) (did not) know the body after death.													
22b. SIGNATURE <i>Stephen C. Schimpff</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/20/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen C. Schimpff, M.D.		22e. ADDRESS 22 S. Greene St.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-22-86		23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland							
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.		ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

00-07284

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

[IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.]

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR		8 6		1 4 4 0 6		REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FANNIE GRACE LOCKARD					2a. DATE OF DEATH MONTH DAY YEAR May 6, 1986			2b. HOUR 12:00 PM		
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec 12 1895		6. AGE (YEARS AT BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home (936 Old Westminster Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FORMERLY OF WORKING LIFE) Factory - Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Lockard					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada Zella Taylor					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-2784		17. INFORMANT ADDRESS Mrs MINA LOCKARD 21157 936 Old West Pike, Westminster, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Impression</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Senile Dementia -</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u> <u>10 yrs</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>April 15</u> , 19 <u>86</u> , to <u>May 6</u> , 19 <u>86</u> , that (1) (we) lost saw the deceased alive on <u>May 5</u> , 19 <u>86</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W H Ford MD				DEGREE MD				22c. DATE SIGNED 5/6/86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Ford MD				22e. ADDRESS 3223 Main St Box E Manchester, Md 21102						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5-9-85		23c. NAME OF CEMETERY OR CREMATORY SANDYMOUNT		23d. LOCATION CITY OR TOWN COUNTY STATE WESTMINSTER, CARROLL MD.				
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR MAY 19 1986		25b. REGISTRAR'S SIGNATURE John Davidson				

MEDICAL CERTIFICATION

00-07494

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH86 14407
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
FIRST MARY		F		W	
MIDDLE ALICE					
LAST LUKAS					
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH	
MONTH DAY YEAR		81		Carroll County MD.	
5 20 65		81			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Maryland		U.S.A.			
9. CITY OR TOWN OF DEATH		10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		11a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Westminster		Carroll County Hospital		housewife	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. KIND OF BUSINESS OR INDUSTRY	
Md. Baltimore City		home			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md.		Baltimore City		Baltimore City	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO	
John Tall		Rita Sanders			
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS	
Frank O. Cave		215-48-0148		332 Clear Ridge Rd.	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		21. IMMEDIATE CAUSE (a)		22. DUE TO, OR AS A CONSEQUENCE OF	
		Cardiac arrest		Arteriosclerotic Heart disease	
23. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		24. DUE TO, OR AS A CONSEQUENCE OF		25. (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
26a. DATE OF OPERATION		26b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
28a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE	
29. I certify that (I) (this hospital) attended the deceased from 5-20-1986, to 5-21-1986, that (I) (we) last saw the deceased alive on 5-21-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
30a. SIGNATURE		30b. DEGREE		30c. DATE SIGNED	
CHITRACHEDU N AGANNA MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		5/21/86	
31a. PHYSICIAN'S NAME (TYPE OR PRINT)		31b. ADDRESS		32. DATE RECD. BY REGISTRAR	
CHITRACHEDU N AGANNA		700 + poole Rd Westminster MD 21157		MAY 23 1986	
33a. BURIAL, CREMATION, REMOVAL (SPECIFY)		33b. DATE		33c. NAME OF CEMETERY OR CREMATORY	
Cremation		5/22/86		Carroll Cremation	
34. FUNERAL DIRECTOR		35. DATE RECD. BY REGISTRAR		36. REGISTRAR'S SIGNATURE	
NAME D. D. Hartzler		ADDRESS New Windsor			



1952-1953



1952-1953

00-06144

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 0 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Luella Mills Martin			2a. DATE OF DEATH MONTH DAY YEAR 5-6-86		2b. HOUR 7:55 AM
3. SEX Female	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 8 15 1897		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Sykesville Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center Mrs. Building		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
13a. USUAL RESIDENCE (IF NURSING HOME, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland		13b. CITY OR TOWN Yarrowsburg		13c. STREET ADDRESS / ZIP CODE None 21758	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW MILLS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FANNIE POFFENBERG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-50-0667		17. INFORMANT ADDRESS Records, Springfield Hosp. CTR.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 2 weeks
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Atherosclerotic Cardiovascular disease with evidence of remote infection					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Jan 11 , 19 36 , to May 6 , 19 86 , that (I) (we) last saw the deceased alive on May 5 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did) (did not) view the body after death.					
22b. SIGNATURE Tom Cooper M.D.		DEGREE MD		22c. DATE SIGNED May 6, 86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert M. Cooper MD		22e. ADDRESS SPRINGFIELD Hosp.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-8-86		23c. NAME OF CEMETERY OR CREMATORY Brownsville Hgts. Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Brownsville, Wash. Co., Md.		24. FUNERAL DIRECTOR NAME ADDRESS John H. Bast, Jr. Boonsboro, Md.			
25. DATE RECEIVED BY BURIAL REGISTRAR		25. REGISTRAR'S SIGNATURE MAY 13 1986			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. BRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, always any injury, or other traumatic event that the medical examiner has identified as the cause of death.

BP

Own name

Name

Address

City

State

8

John H. Galt, Jr., Secretary, N.Y.

John H. Galt, Jr., Secretary, N.Y.

00-06517

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86 14409

1- FOR
STATE REGISTRAR KATHERINE MORHISER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) KATHERINE MORHISER			2a. DATE OF DEATH MONTH 5 DAY 12 YEAR 86 2b. HOUR 1345 M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH January DAY 10 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARTROLL County
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WESTMINSTER NUN & CONV. CTR.		12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Catonsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 200 Brookside Drive 21228
14. FATHER'S NAME FIRST Harry MIDDLE LAST Conklin		15. MOTHER'S MAIDEN NAME FIRST Minnie MIDDLE LAST Nieberlein		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-07-5100D	17. INFORMANT ADDRESS Susanne Gutberlet 200 Brookside Drive Catonsville, MD. 21228		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4 MONTHS DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DS 8 YEARS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 1/26 19 86 to 5/12 19 86 , that (I) (we) last saw the deceased alive on 5/12 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Daniel I. Welliver MD		DEGREE MD		22c. DATE SIGNED 5/12/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD		22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD		
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) Burial	23b. DATE 5/15/86	23c. NAME OF CEMETERY OR CREMATORY Gardens Of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24. FUNERAL DIRECTOR Leland M. & Russell C. Witzke Funeral Homes P.A.		25. DATE REC'D. BY REGISTRAR MAY 14 1986		
1630 Edmondson Avenue, Catonsville, MD. 21228		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION



00-05773

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 6 1 4 4 1 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
EMMA Cornelia B		Payne						5/5/86		4:15 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		10 10 08		77		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				Carroll							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Westminster		Carroll County General Hosp		Housewife									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Carroll		Mt. Airy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5950 Ridge Rd. 21771					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Howard C. Baer		Stella C. Kefauver											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No		219-12-0662		Robert R. Payne,		Item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) CVA										Several months.			
DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) Hypertension													
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aspiration pneumonia, Sick sinus Syndrome													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost													
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATED							
Dinesh Kalaria, M.D.		MD				5/5/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
		908 Washington St., Westminster, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
Burial		May 7, 1986		Lutheran		Middletown Frederick, Md.							
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
L. Molesworth, P.A.		Damascus, Md.				MAY 6 1986		J. J. J. J. J.					

BP

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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

86

REG. NO.

14411

1. DECEASED NAME (TYPE OR PRINT) GERTIE LaRue RHODERICK			2a. DATE OF DEATH MONTH 5 DAY 20 YEAR 86			2b. HOUR 11:50 AM					
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 15 YEAR 30		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS		IF UNDER 1 YEAR MONTHS 11 DAYS 5		IF UNDER 24 HRS. HOURS 11 MIN. 50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY —			
13a. STATE Md				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4432 Salem Bottom Rd 21157	
14. FATHER'S NAME FIRST Howard MIDDLE Lee LAST Kenney				15. MOTHER'S MAIDEN NAME FIRST Gertrude MIDDLE Young LAST Young							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-24-9032		17. INFORMANT ADDRESS Carroll E. Rhoderick, Same As #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 2 DAYS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ANGINA - DIABETES - HYPERTENSION											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5-18 19 86 to 5-20 19 86 , that (I) (we) last saw the deceased alive on 5-20 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE (Signature)		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-20-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. PATPABA				22e. ADDRESS 224 W. BALTIMORE AVE WESTMINSTER							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-23-1986		23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial		23d. LOCATION CITY OR TOWN Frederick, Md.					
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR MAY 23 1986		25b. REGISTRAR'S SIGNATURE (Signature)					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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00-06892

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of a patient be certified within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 6		1 4 4 1 2		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eugene Clyde Rice				2a. DATE OF DEATH MONTH DAY YEAR May 13, 1986		2b. HOUR 1:47 A.M.			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 22, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS 10 21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.			
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 902 N. Main St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 902 N. Main St. 21771	
14. FATHER'S NAME FIRST MIDDLE LAST Clyde H. Rice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dessie Irons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-10-7040		17. INFORMANT Baltimore, Md. Donald E. Rice, 1581 Williams Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Rectum DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): COPD & SMOKING									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5-9-86 19 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1-15 , 19 85 , to 5-13 , 19 86 , that (I) (we) last saw the deceased alive on above (I) (we) (did) (did not) view the body after death. and that (I) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE Donald E. Miller				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-14-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-15-1986		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.			
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.				25. MAY 16 1986 BY REGISTRAR'S SIGNATURE J. Davidson-Randall					

BP

3 00-07621

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 1 3
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD E. ROSNER		2a. DATE OF DEATH MONTH DAY YEAR MAY 21, 1986		2b. HOUR 10 05 P.M.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 27 1928		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD	
10. CITY OR TOWN OF DEATH WESTMINSTER, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL		12. OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRONIC TECHNICIAN		13. TELEVISION, STERO, ETC. 20874	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN GERMANTOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 13215 DAIRYMAID DRIVE 20874	
14. FATHER'S NAME FIRST MIDDLE HARRY ROSNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE FANNY MARGOLIUS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO 579-30-2718		17. INFORMANT ADDRESS GOLDIE M. ROSNER, 13215 DAIRYMAID DRIVE GERMANTOWN MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5/6/86
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from 5/6 19 86 to 5/21 19 86, that (1) we lost saw the deceased alive on 5/21 19 86, and that (a) my opinion death occurred on the date and hour and from the causes stated above, (1) we did not view the body after death.							
22b. SIGNATURE Howard B. Canham MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/21/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD B. CANHAM, MD				22e. ADDRESS 215 WASHINGTON HIGGS MANS CTR			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 5/23/1986		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION PRINCE ADDELPHI, GEORGE'S, MARYLAND	
24. FUNERAL DIRECTOR (NAME) DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME (ADDRESS) 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR MAY 26 1986		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1906

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE, MAY 1, 1905

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS, 1906.

00-06794

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		86		14414		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) WILBERT E Ruby				2a. DATE OF DEATH MONTH DAY YEAR 5 15 86		2b. HOUR 6:05 AM			
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 27 06		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LYNH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY Manufacturing	
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4412 Hanover Pike 21102	
14. FATHER'S NAME FIRST MIDDLE LAST George S Ruby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Shaffer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 197-01-3557		17. INFORMANT ADDRESS Elmo Ruby - 48 Hampton Pkce - Walkeville Md. 21793					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 5/15/86, 19____, to 5/15/86, 19____, that (1) (we) lost saw the deceased alive on N/A, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. V. Faustino, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 5/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. V. FAUSTINO, M.D.				22e. ADDRESS Hampton Pike, Maryland					
23a. BURIAL, CREMATION, REMOVAL (OTHER) Burial		23b. DATE May 17, 1986		23c. NAME OF CEMETERY OR CREMATORY St. Davids Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Hanover, York, Penna.			
24. FUNERAL DIRECTOR H. E. Ehlhardt				ADDRESS Manchester, Md.		25a. DATE REC'D. BY REGISTRAR MAY 16 1986		25b. REGISTRAR'S SIGNATURE John Davidson	

MEDICAL CERTIFICATION

29

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8614415

REG. NO.

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) OTTO Drechsler SEIPP		2a. DATE OF DEATH MONTH DAY YEAR 5-23-86		2b. HOUR 720 AM	
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 04-20-05		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard		12b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Lewis Seipp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Drechsler		13e. STREET ADDRESS / ZIP CODE 627 Hook Rd. 21157			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-01-9184		17. INFORMANT Christina Seipp Westminster, Md. 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) CHOLECYSTITIS SMALL BOWEL ILLNESS SEVERE PARKINSON'S DS.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 5/11 , 19 86 , to 5/23 , 19 86 , that (1) (we) last saw the deceased alive on 5/22 , 19 86 , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE Howard G. Latham MD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/23/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD G. LATHAM MD		22e. ADDRESS 215 WASHINGTON HOTEL MD5 CTR					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-26-86		23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.	
24. FUNERAL DIRECTOR Thomas D. Fletcher & Son F.H.		25. DATE REC'D. BY REGISTRAR MAY 26 1986		26. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

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00-08982

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 1 6
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Sharon L Stanton			2a. DATE OF DEATH MONTH 5 DAY 31 YEAR '86		2b. HOUR 3:10 am
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 9 DAY 13 YEAR 46		6. AGE (IN YEARS LAST BIRTHDAY) 39	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Hosp & Carel. Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.			13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST Edward MIDDLE Hubert LAST Stein			15. MOTHER'S MAIDEN NAME FIRST Ruth MIDDLE Ann LAST Stein		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-46-4526		17. INFORMANT ADDRESS Ira A. Stanton 3825 Shiloh Ave. Hamp	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral breast carcinoma with DUE TO, OR AS A CONSEQUENCE OF metastases. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug 28 , 19 85 , to Aug 31 , 19 85 , that (I) (we) last saw the deceased alive on Aug 28 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE H.C. Jamieson, M.D.				22c. DATE SIGNED 5/31/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 05-31-86		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation	
23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.		24. FUNERAL DIRECTOR NAME Eline Funeral Home ADDRESS Hampstead Md. 21074			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE J. H. Davidson	

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been issued by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. The funeral director must have carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		5 - 7 - 86		12:10			
Eddie Glen Stidham									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR		73 YRS.		MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Finksburg		2525 Hillandale Park 1 Lot 2		Maintenance					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Carroll		Finksburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2525 Hillandale Park 1 Lot 2	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Ambrose		MaryAnn Phillips		NO		229-05-8501		Margie Green Sykesville, MD 21784	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
acute myocardial infarction				CAD		minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		sclerosing cholangitis		AODM					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 19 85, to April 19 86, that (I) (we) last saw the deceased alive on 4/24/19 86, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		D.S. KALARIA		MD		5/7/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
D.S. KALARIA		908 Washington Rd. Westminster Md 21157		BURIAL		5-10-86		Mt. Zion Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE	
HAIGHT FUNERAL HOME SYKESVILLE, MD FOR BAKER FUNERAL HOME POUND, VIRGINIA		MAY 9 1986							

51980-0

433-1 NOTED 10/10/68

11/11/68

00-07427

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 1 4 4 1 8

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Connie Jean Swartzbaugh			2a. DATE OF DEATH MONTH DAY YEAR 5 21 1986		2b. HOUR M 10
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 4 3 1939		6. AGE (IN YEARS LAST BIRTHDAY) 47	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2041 Sykesville Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Health Dept.
13a. STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 2041 Sykesville Rd.
14. FATHER'S NAME FIRST MIDDLE LAST Lester C. Mann			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Ward		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-34-1981		17. INFORMANT Donald W. Swartzbaugh Sr. West.Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Breast Cancer**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/26 , 19 85 , to 5 , 19 86 , that (I) (we) last saw the deceased alive on 7/26 , 19 85 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Norman I. Goldstein		DEGREE MD	22c. DATE SIGNED 5/22/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman I. Goldstein, M.D.		22e. ADDRESS 218 Washington Hts. Med. Ctr., Westminster, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-24-86	23c. NAME OF CEMETERY OR CREMATORY Providence Cemetery Gamber	23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.
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24. FUNERAL DIRECTOR
NAME **Thomas D. Fletcher & Son P.H.**
25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
May 23 1986

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the certificate to the Registrar. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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CONFIDENTIAL

Page 2

1. The first of the three items is a letter from the

2. The second item is a letter from the

3. The third item is a letter from the

4. The fourth item is a letter from the

5. The fifth item is a letter from the

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CONFIDENTIAL

Page 3

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00-05565

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Elizabeth M. Wayland		8 6 1 4 4 1 9		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
ELIZABETH		WHAYLAND		5 2 86		22 15		P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH DAY YEAR		76 76		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Carroll County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County General Hosp.		Section Manager		Retail Stores			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
Maryland		Baltimore		Woodlawn		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1627 Ingleside Ave. 21207	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Lee		Addie		NO		216-34-9756		Sue Roe 3404 Schaefer Dr. Hampstead, Md. 21074	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration & acute hypoxia 2° Racto</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Leukemia & multiple coagulopathies and granulocytopenia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>5/2</u> 19 <u>86</u> to <u>5/2</u> 19 <u>86</u> that (I) (we) last saw the deceased alive on <u>5/2</u> 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
<u>Park N. Espenschade M.D.</u>						5/2/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Park N. Espenschade M.D.		Carroll County General Hospital		Westminster, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		5/5/86		Woodlawn Cemetery		Woodlawn Maryland			
24. FUNERAL DIRECTOR 1630 Edmondson Ave. Catonsville, Md. 21228				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Leroy M. & Russell C. Witzke Funeral Home				MAY 5 1986		<u>J. H. Anderson</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

REG. NO.

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1. DECEASED NAME (TYPE OR PRINT) HARRY EDGAR YEAKLE			2a. DATE OF DEATH MONTH DAY YEAR May 19 1986			2b. HOUR 5:15 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 13 1915		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	

10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL COUNTY GEN.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TOOL & DIE MAKER		12b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING	
13a. STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 1770 Deep Run Rd 21102							

14. FATHER'S NAME FIRST MIDDLE LAST HARRY EDGAR YEAKLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIAN MARKS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03 1270	
17. INFORMANT Mrs Harry Yeakle		17b. ADDRESS 1770 Deep Run Rd Manchester, Md 21102	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 yrs	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Chronic obstructive pulmonary Disease			
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19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (1) this hospital attended the deceased from April 19 1954 to May 19 1986 , that (1) (we) last saw the deceased alive on 2110/86 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE W H Hoard MD		DEGREE		22c. DATE SIGNED 5/20/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Foard MD		22e. ADDRESS 3223 Main St Box E Manchester, Md 21102			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE May 22, 1986		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE FINNLSBURG CARROLL MD	
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24. FUNERAL DIRECTOR NAME R. Larry [unclear]		ADDRESS ECKHART FUNERAL CHAPEL MANCHESTER, MD.		25a. DATE REC'D. BY REGISTRAR MAY 21 1986		25b. REGISTRAR'S SIGNATURE [unclear]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the copy of pages 1 and 2 and place them in the container with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

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DEPARTMENT OF THE ARMY

POST OFFICE BOX 1000

[Faint, mostly illegible handwritten text covering the majority of the page, likely a letter or report.]